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IN THIS ISSUE

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Identify and Manage Drug-seeking Patients in the Emergency Department

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The issue of drug-seeking is important for any health care provider, but can be of particular relevance to emergency department (ED) staff. This article analyzes the laws applicable to assessing and treating pain in the ED setting, and considers various strategies suggested in the literature for managing suspected drug-seeking behavior.

'Drug-seeker' Defined

Although there are not currently any evidence-based definitions of drug-seeking behavior in the relevant literature,[1-3] the term "drug-seeker" has been routinely used to describe those patients who are perceived to be engaging in behaviors for the purpose of obtaining drugs. It is important to distinguish between those patients seeking drugs for a legitimate purpose, such as undertreated chronic pain, and those patients seeking drugs to abuse them or use them for an illegal purpose. As used herein, the term "drug-seeker" only refers to those seeking drugs for the latter purpose.

Various studies have identified factors that may be considered in determining whether a patient is a drug-seeker. For instance, alteration or forgery of prescriptions, claims of lost or stolen medications, abusive or threatening behavior, seeking care from multiple providers ("doctor shopping"), not following up with primary care appointments, and requesting particular medications have all been suggested as possible identifiers of drug-seekers.[1,3,4] Similarly, a study of nearly a thousand nurses revealed that the following behaviors most often led them to believe a patient was a drug-seeker: going to different emergency departments for opioids, telling inconsistent stories of pain or medical history, or asking for a refill due to lost or stolen medication.

Identifying and effectively managing drug-seeking behaviors can be of great importance, and particularly difficult, in the ED setting. Pain is frequently seen in the ED. In fact, it has been named as the number one reason that patients present to the ED, and the pain rating is frequently high, such as eight out of 10.[5] The ED physician must not only treat the pain, but also diagnose the cause of it.[5]

Sometimes pain is a symptom of another problem, but pain can also be the final diagnosis itself.

In the ED, the staff frequently do not know the patient, and therefore, are more susceptible to doctor shopping and other types of deceitful behaviors.[3] EDs are also frequently a place of last resort for those seeking drugs. Estimates in 2005 suggested that an ED that sees 75,000 patients per year receives up to 262 monthly visits from drug-seekers.[6]

Law Applicable to Identification and Management of Drug-seekers

Although several federal and state laws govern the operation of the ED as it relates to providing medication to patients, this article focuses on the applicable federal laws.

EMTALA. To comply with the Emergency Medical Treatment and Active Labor Act (EMTALA), a patient presenting to an ED must be provided with an appropriate medical screening examination to determine whether or not an emergency medical condition (EMC) exists. If such a condition exists, the hospital must provide "any necessary stabilizing treatment," or an appropriate transfer, as set forth in the EMTALA regulations.[7] The screening examination to determine if an EMC exists must include a pain assessment. "Emergency medical condition" is defined in EMTALA as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) . . . ."[7] Not only must the physician determine if pain exists during the screening, but he or she must also determine if the pain indicates that a critical condition exists.

Despite the requirement to assess pain and determine if a critical condition exists, it is not clear if EMTALA requires the treatment of pain. The phrase "stabilizing treatment" in and of itself does not appear to require providing pain medication to patients. EMTALA defines "stabilize" as "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely. . . ." From this definition, EMTALA appears to only require treatment of pain if that pain would result in deterioration of the patient's EMC.

Where the patient requests pain medication, it appears the hospital is required to meet an increased standard of medical screening. The Interpretive Guidelines state:

> *If an individual presents to an ED and requests pharmaceutical services [medication] for a medical condition, the hospital generally would have an EMTALA obligation. Surveyors are encouraged to ask probing questions of the hospital staff to determine if the hospital in fact had an EMTALA obligation in this situation [e.g., did the individual present to the ED with an EMC and informed staff they had not taken their medication? Was it obvious from the nature of the medication requested that it was likely that the patient had an EMC?]. The circumstances surrounding why the request is being made would confirm if the hospital in fact has an EMTALA obligation. If the individual requires the medication to resolve or provide stabilizing treatment of an EMC, then the hospital has an EMTALA obligation. Hospitals are not required by EMTALA to provide medication to individuals who do not have an EMC simply because the individual is unable to pay or does not wish to purchase the medication from a retail pharmacy or did not plan appropriately to secure prescription refills.*[7]

This interpretive guideline indicates that where a patient is requesting medication the staff should, in

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addition to normal medical screening procedures, ask additional probing questions to determine whether the medication is required to "resolve or provide stabilizing treatment of an emergency medical condition." The hospital is not required to provide medication where it is not necessary to stabilize the patient.

The Joint Commission. Unlike EMTALA, the Hospital Accreditation Standards of the The Joint Commission (JC) requires the management of pain.[8] Specifically, the JC requires, "[t]he hospital [to] assess and manage the patient's pain." The JC standards indicate that the hospital must assess and reassess pain. Further, it must "manage" the pain. This management must be in the form of either treatment for the pain, or a referral for such treatment. Where a patient is suspected of being a drug-seeker after assessment and reassessment, and the hospital does not want to provide medication, a referral to a pain management doctor or a primary care physician would be acceptable under the standards.

Code of Ethics. The Code of Ethics for ED Physicians explains that emergency physicians are in a unique circumstance.[9] They must treat patients that often arrive in the emergency department with acute illnesses or injuries requiring immediate care, leaving the physician with limited time to gather data, consult with others, and deliberate about treatment. Furthermore, the Code recognizes that emergency staff typically have little or no prior relationship with their patients, and cannot rely on earned trust or prior knowledge. Finally, the Code indicates that emergency physicians have been given the social role in the United States of being the "providers of last resort" for many patients with little or no other access to health care.[9]

According to the Code, the emergency physicians' primary professional responsibility is "patient welfare." Emergency physicians must "respond promptly . . . in order to prevent or minimize pain and suffering." This requirement indicates that an emergency physician is ethically bound to try and minimize or prevent a patient's pain. Nonetheless, the Code recognizes that the emergency physician does not only owe this duty to his or her patients, but also owes a duty to society. Indeed, the Code states that the duty to society sometimes, "transcend[s] duties to individual patients." This statement could be deemed to encompass the duty to prevent drug addiction, which can be injurious to society. Therefore, while an emergency physician has the ethical duty to relieve or prevent pain, where he or she suspects a patient to be an illegitimate drug-seeker, the duty to society may be greater than the duty to provide pain mediation, and the physician may, in some circumstances, withhold pain medication.

Case Law. Case law on the issue of drug-seekers is limited. What limited case law exists demonstrates a tension between the need to treat pain and the concern over treating patients without a legitimate need for the medications.

In two recent cases in California, families of patients sued for medical malpractice where the physicians allegedly undertreated pain. Both cases involved end of life care, not care in the ED. In *Bergman v. Chin,* A California jury returned a verdict against Wing Chin, MD, and awarded $1.5 million in damages.[10] Dr. Chin was an internal medicine specialist at Eden Medical Center. William Bergman was suffering from end-stage lung cancer and complaining of pain ranging from 7 on a scale of 10 to 10 on a scale of 10. Dr. Chin was alleged to have failed to prescribe pain medication strong enough to provide relief.[10]

Similarly, in the case of *Tomlinson v. Bayberry Care Ctr.*, the family of Lester Tomlinson filed suit against two physicians alleged to have undertreated the pain he suffered due to mesothelioma.[11] The lawsuit was settled for an undisclosed sum. These cases demonstrate the possibility of successful plaintiffs' suits where a health care provider is alleged to have withheld pain management and thus violated the standard of care.

At the other end of the spectrum, the physician faces the possibility of federal charges of drug trafficking where he or she prescribes medication in violation of federal law.[12] These cases are exceedingly rare.[13] In order to find a physician guilty of violating drug trafficking laws, the government must prove:

1.) that the defendant distributed or dispensed a controlled substance;
2.) that the defendant acted knowingly and intentionally; and
3.) that the defendant's actions were not for legitimate medical purposes in the usual course of his professional medical practice or were beyond the bounds of medical practice.[13]

Strategies to Identify and Manage Drug-Seekers

Several strategies for identifying and managing drug-seekers have been identified in the literature.

Prescription Abuse Checklists. One strategy suggested in the literature is utilization of "prescription abuse checklists."[14] The checklists are of two different types. The first is to be filled out by the practitioner, based upon obtaining the patient's history. It involves items such as "excessive focus on opiate issues during clinic visits," "multiple phone calls or visits about opiate prescriptions," and "a pattern of prescription prob-

lems." Where the practitioner finds that the patient meets three out of five of the criteria, the patient is classified as an opioid abuser.[14] This type of checklist may not be effective in the ED, where the health care providers may not have a working knowledge of the patient's history, and it does not distinguish between legitimate and illegitimate drug-seeking.

The second type of checklist employs a self-report form to be completed by the patient. The checklists are more successful when the questions are less "objectionable" to answer. For instance, a less objectionable question might be: "is there a history of alcohol or substance abuse in your family?" or "have you ever had any legal problems or been charged with driving while intoxicated?"[14]

One drawback with any type of checklist is that they are heavily dependent on patient self reporting. This may not be reliable, particularly in the ED setting, where there is no established trust or prior knowledge. Another drawback is that physicians in the ED do not have the time to utilize these checklists.

Alternatives to Opioids. Prescription strength opioids are highly sought out as drugs of abuse. In fact, research has showed that the street value of prescription narcotics is greater than both marijuana and heroin.[6] Therefore, a third strategy recommended in the literature is to prescribe alternatives to opioids,[6,14,15] or in some instances, alternatives to short-acting opioids. Where a patient is believed to be addicted to opioids, these medications may be avoided altogether.[6,14,16] Alternatives may include acetaminophen, salsalate, or non-steroidal anti-inflammatory drugs (NSAIDs).

One study suggests that, where appropriate, physicians may use a method of "compassionate refusal" by expressing compassion for the patient's condition, but refusing to treat with opioids.[14] The physician may "turn the tables" on the patient by discussing issues of dependence.[14]

Referral to Social Services or Case Management. Some literature also recommends referring patients to social services or case management.[14-16] This may be particularly helpful when a drug-seeker appears to be addicted to medications, but is also suffering from chronic pain. In such instances, the patient may need to be managed in an inpatient facility where he or she receives pain medication, as well as treatment for addiction in a controlled setting.[14,15] The social worker or case manager can direct the patient to these services.

Similarly, the patient can be referred to a pain specialist (either through social services, or directly by the physician). A pain specialist can prescribe narcotics under a tightly controlled atmosphere and also educate the patient on pain management techniques that do not involve medications, such as acupuncture. Alternatively, the social worker or case manager can work with the patient to develop certain conditions for receiving narcotics.[15]

Where a health care provider chooses to refer the patient to social services or case management, a full pain assessment and screening must still be done. The health care provider may need to prescribe pain medication (opioid or non-opioid) for the time period until the patient is able to enter the inpatient facility or see the pain specialist.

Red Dot Alert System. A final strategy recommendation is a "red dot" alert system. In this system, a red dot would be placed on the charts of all patients seen more than three times in the preceding six months.[16] If a health care provider is treating a patient and sees a red dot on the chart, he or she would know to review all of the past records for that patient, even if the current complaint would not otherwise precipitate a review of past medical records.[16]

This system avoids HIPAA and EMTALA concerns because there is no separate file kept on the patient. All information is kept in the patient's normal medical records. The red dot system also has the benefit of avoiding stigmatizing suspected drug seekers. Instead, this system simply instructs the health care provider to take a more complete look at the patient's history. A full and complete assessment and screening of the patient would still take place and, in fact, may be more detailed than it would have been. In order to avoid EMTALA problems, the red dot policy should emphasize that it is a patient safety mechanism, and the EMTALA screening examination is not altered due to the presence of a red dot.

Under this system, the health care provider would also know, by virtue of the red dot, the importance of complete documentation of medication with this patient, including the patient's complaints and presentation, the prescription given, and the reasons therefore. The providers should record only factual statements of the events and the health care provider's actions. This will protect against patients taking steps such as suing for defamation. In one such case, a patient filed a lawsuit for defamation arising out of entries in her medical records where physicians indicated suspicions of "drug-seeking." Her case was thrown out prior to trial because the statements in her record were factual and "truth is an absolute defense" to a claim for defamation.[17]

The physician acting under the red dot system is able to prescribe any medication believed necessary, including opioids. At the same time, this system offers a more "unified policy for managing" the patient's condition, particularly where there are no

objective signs of injury or illness to be routinely treated with opioids.[16] The red dot system can help distinguish true drug-seekers from patients suffering from chronic pain.

Conclusion

Drug-seeking behavior is an important issue for any health care provider, but it is particularly critical for emergency physicians to be able to identify and manage drug-seeking behavior. EMTALA, Joint Commission Standards, the Code of Ethics for ED Physicians, and case law, require that emergency health care providers conduct thorough pain assessments and manage pain, by either treatment, or referral for treatment.

Several strategies have been suggested for management of drug-seekers, including utilizing checklists, avoiding use of opioids, referring the suspected drug-seekers to social services or case management, and utilizing a red dot alert system. Regardless of the system used, it is most important that the health care provider conduct a thorough and individualized assessment of the patient and fully document the treatment decisions.

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Do You Find Yourself Defending a Lawsuit Alleging Missed MI?

Documentation can "make or break" the outcome

(**Editor's note**: This is the second of a two-part series on missed myocardial infarction (MI) cases. This month, we cover specific documentation practices which can impact the outcome of a patient's lawsuit alleging a missed myocardial infarction. Last month's *ED Legal Letter* examined ways to reduce liability risks stemming from triage.)

A patient with crushing chest pain and shortness of breath somehow ends up waiting a prolonged time in your ED waiting room, has a myocardial infarction (MI) and dies; or

A patient is appropriately discharged from your ED with a non-cardiac diagnosis, and has an MI hours later.

These are two very different scenarios, but both are likely to lead to a malpractice lawsuit. "Sudden death due to myocardial infarction and/or atherosclerotic coronary artery disease occurs in more than 250,000 patients each year," says **Corey M. Slovis,**

MD, professor and chairman of the Department of Emergency Medicine at Vanderbilt University Medical Center in Nashville.

Patients at increased risk include those with known coronary disease, hypertension, hyperlipidemia, diabetes, smokers, those with a family history of coronary disease at an early age, obese and/or inactive individuals, cocaine users, and also those with underlying diseases such as systemic lupus erythematosus, rheumatoid arthritis, chronic inflammatory diseases, and HIV-positive patients on certain antiretroviral agents.

"Some of these patients may be appropriately evaluated in the ED, only to succumb to sudden death hours or days later," says Slovis. Some patients who ultimately go on to suffer sudden death will have been seen in the ED for complaints totally unrelated to their ultimate cause of death, while others may be seen for chest pain, shortness of breath, weakness, dizziness, near syncope, nausea, vomiting, or vague abdominal pains.

"All of these are potentially due to coronary disease, and all, as the plaintiff's attorney will allege, are the reason the patient should never have been allowed to leave the ED," says Slovis.

If the patient presents prior to the evolving acute MI, it's conceivable that he or she could be seen for an unrelated illness and then shortly thereafter develop an acute MI, says **A. Clinton MacKinney, MD, MS**, a board-certified family physician delivering emergency medicine services in rural Minnesota. In this case, a patient may erroneously believe the acute MI is linked to the previous illness.

"However, our greatest fear is 'atypical' angina without AMI masquerading as heartburn, muscle strain, or even anxiety," says MacKinney. "In these cases, I believe the science is clear that clinical judgment is superior to any testing in the effort to rule in or rule out an early MI. Unfortunately, that's tough to defend in a test-oriented society."

Reduce Risks with Good Documentation

Regardless of the specific allegations in a missed MI lawsuit, "Documentation is always front and center in these cases," says **Joseph P. McMenamin, MD, JD, FCLM**, a partner at Richmond, VA-based McGuireWoods. McMenamin is also a former practicing emergency physician.

"Write a very good history including all the pertinent negatives and positives," says McMenamin. "If it is the case that the pain is atypical and it's not related to exertion and not relieved by rest and not accompanied by the classic associated symptoms, take the time to let the record show that. Those extra few seconds that you take are really very valuable."

According to **Louis Graff, MD,** professor of emergency medicine at the University of Connecticut School of Medicine in Farmington and associate chief of emergency medicine at the Hospital of Central Connecticut in New Britain, if the diagnosis of MI is missed, "what saves the physician is if their documentation is complete, and their disposition—home versus observation versus admit—is consistent with what their documented cardiac risk stratification shows is correct."

Graff adds that since there are various cardiac risk stratification models, the healthcare organization should have a policy with an agreed upon, evidence-based cardiac risk stratification standard. "Compliance with this would offer the physician protection," says Graff. "If there is a bad outcome, the best mitigating factor is the physician following the institution's standards."

MacKinney says that documentation of symptoms and appropriately linking those symptoms to a non-cardiac diagnosis is critical. "In these cases, I also try to discuss with the patient and the family our ongoing inability to make the correct diagnosis 100% of the time - and maybe that is why heart disease continues to be the number one killer of Americans!" he says. "I also carefully discuss the importance of prompt follow-up if there is any worsening or new symptoms."

ED patients that are not clearly non-cardiac are often admitted for observation, repeat lab and EKG testing, and stress testing, if available. "But it is important to note that even this conservative approach is not foolproof," says MacKinney.

MacKinney says compliance with generally accepted clinical protocols for rule out MI or chest pain should offer protection-"protection for the patient's health and protection for the physician from liability. I would also like to think that a physician's willingness to acknowledge with the patient the challenge of angina diagnosis, the physician's willingness to answer every and all patient and family questions, and the physician's clear and specific discussion of follow-up plans would be important."

According to McMenamin, "You should have, even in this era of stingy reimbursement, a pretty low threshold for getting an EKG on almost anybody who could have a reasonable basis to at least raise the question, 'Could this be cardiac?'"

There is also a risk of the ED physician being so focused on MI that other sources of thoracic distress that can be equally dangerous, aren't considered. "They don't get as much publicity because they are not

quite so common, but a dissecting aortic aneurysm or a pulmonary embolus for example, are just as potentially lethal as a heart attack," says McMenamin. "So those have to be part of the differential, as well."

Consult with Others

Whereas some chest pain patients are straightforward and can simply be diagnosed and treated, other cases leave room for doubt even for the most experienced ED physician. "Even though you're pretty confident that it's noncardiac, if you have someone with a cardiac history who perhaps is under the care of a cardiologist, then you might err on the side of caution and check in with the physician," says McMenamin. "You improve your position considerably if you have taken the time and trouble to confer, even if only over the phone, with the internist or cardiologist on call and documented his advice on the decision that you reach."

It's also a good idea to contact the patient's primary care physician if there is one, and document his or her opinion on the case. "It isn't that you are expected to be perfect. You are just expected to be reasonable," says McMenamin. "And by conferring with another physician, you are able to say that, 'I'm a reasonable physician and here's what I think. But because I'm especially cautious, I consulted another reasonable physician, Dr. Jones, who unlike me has seen this case a dozen times before.' Of course, this is time-consuming and time is at a premium in the ER. But when you can show something like that, you're in much better shape."

As for the possibility that the plaintiff's attorney might use this consultation to raise questions about the clinical competence of the ED physician, McMenamin says it's highly unlikely and, in fact, would likely backfire.

"I have never seen that, but if anyone wants to try it and I'm on the defense side, I say bring it on. The formula for standard of care varies state to state, but the basic formula is, you do what a reasonably prudent ER doc would do under similar circumstances."

A consultation in this scenario simply reflects the fact that "it's prudent to take advantage of better information," says McMenamin. "If I'm looking at a patient's EKG and the ST waves look a little funny to me, but I have the solace of knowing that two months ago an EKG was done and looked the same way, that's very helpful to me, and to him," says McMenamin.

In any event, McMenamin notes that the ED physician doesn't lose a case because somebody thinks he's not competent, but because he breached the standard of care and caused harm. "I don't think I'd have even the slightest difficulty finding a highly qualified expert witness to say it couldn't possibly breach the standard of care to take five minutes on the phone gaining information that another physician may be uniquely qualified to provide."

McMenamin adds that making a follow-up call to the patient or their family is a good practice in general, whenever there is some doubt about a diagnosis at the time of discharge. "When it's practicable, and it isn't always, call or have a nurse call a few hours later or the following morning to make sure things are okay," says McMenamin. "And if they are not, then advise the patient to return."

Keys to Successful Defense

Slovis says that for a successful defense of a "missed MI" case, you should have a well-documented ED chart, a correctly read EKG, appropriate lab testing, an objective test correctly performed and interpreted, and appropriate follow-up instructions.

"If a patient is not believed to be suffering from unstable angina, then a good history must lead away from a diagnosis of coronary disease," says Slovis.

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This should include such factors as stating the following as negative: No substernal chest pain made worse by exertion, better by rest, no associated shortness of breath, weakness, or near syncope.

"Comments on ultra-short duration or long history of similar complaints, sharp, or 'pins and needles like" pain, all assist in suggesting a noncardiac etiology," says Slovis. "The physical exam must include a cardiopulmonary exam."

Slovis says that "there are three areas that, to me, make or break a case. The first is getting an EKG and correctly reading it. I urge that all of us finish our reading and then go back through the EKG carefully looking for, and excluding, the five STEMI types by anatomic location."

Secondly, draw cardiac enzymes and correctly interpret them. "If the chest pain is recent, two sets are required," says Slovis. "And the single most important part of the workup, and one that allows a physician to truthfully say he or she did not miss an MI or unstable angina, is an objective test." Slovis says he believes a negative exercise treadmill test, stress echocardiogram, nuclear stress test or a CT coronary angiogram "allows appropriate discharge of patients at some risk for sudden death sometime in the hopefully distant future."

Slovis says that the two worst mistakes an ED physician can make are to either not get an EKG, or to misread one and miss acute ischemia or infarction.

Other common mistakes include not comparing a just-obtained EKG to an older one, not repeating an EKG if the patient has chest pain during the stay, or ignoring a positive cardiac marker value.

"A well-done history and physical, and discussing the case with involvement of the patient's physician, usually provides some mitigating circumstances when the patient is discharged inappropriately," says Slovis. "Carefully arranging outpatient follow-up with a cardiologist who has agreed with the plan is also very helpful."

If the patient's discharge from the ED was truly appropriate, then the documentation must reflect that, says **Jonathan M. Glauser, MD**, chair of the Cleveland (OH) Clinic's Emergency Services Institute. "The chart should describe a history and physical which simply is not consistent with acute coronary syndrome or MI," he says. "Of course, I am assuming that any EKG readings are accurate and that there is nothing missed there."

The history should reflect that serious cardiac concerns were considered and discounted based upon the history, risk factors, prior work-up and presentation. "The nursing record should also demonstrate all of the above. Any inconsistencies must be addressed and documented thoroughly in real time prior to discharge," says Glauser. "Don't even think of changing the record later, although a dated addendum might not hurt."

As for laboratory testing, Glauser says that in general, it doesn't help one's case in court to have one negative set of cardiac markets. "Granted, this shows that the possibility of myocardial infarction was considered. On the other hand, these entities cannot be ruled out based upon one negative finding," says Glauser.

The counter claim could be, for example, that the patient was having atypical symptoms for two weeks, and that there would have been plenty of time for a troponin to become positive. "It is better that an independent reader of the medical record would conclude that the patient couldn't possibly have had an MI or acute coronary syndrome, based upon the history and examination," says Glauser.

What Can Make a Patient's Lawsuit Just 'Go away?'

Be aggressive in your own defense

Inability to find an attorney who will take a malpractice case on a contingency fee basis. An inability to find an expert who can conclude to a reasonable degree of medical certainty that the ED physician breached the standard of care or proximately caused injury/death. Strong defense experts. Strong testimony from defendant physicians. Damaging admissions by the plaintiff's experts at deposition. A decision by the patient or family to resolve the matter now without going through the ordeal of a trial.

These are all factors that can stop a patient's lawsuit against an ED physician from going forward, says **Joseph J. Feltes, JD,** a partner with Buckingham, Doolittle & Burroughs in Canton, OH.

In addition, reforms in some states may make it more difficult for an ED patient to file a malpractice case. **Barbara Pilo, JD,** a counsel attorney in the litigation section of the Dallas office of Fulbright & Jaworski LLP, says that "post-2003 tort reform in Texas, some cases which might have been previously filed are no longer economically feasible to pursue. Court statistics from Dallas County, for example, demonstrate a significant drop in the number of medical liability cases filed in 2008, as compared to prior to the enactment of legislative reform."

Once the case is filed, however, Pilo says that a defendant conceivably could "play a particularly strong hand" by retaining an expert early and disclosing an expert's opinions prior to deadlines that might

otherwise apply. "But in my experience, that is a relatively uncommon scenario," says Pilo. The downside to a voluntary disclosure is that a plaintiff will be undeterred, the case will persist and the sharing of information will only succeed in educating the plaintiff in how to better prepare their case.

"If liability in a case rested on an issue such as statute of limitations or absence of a physician/patient relationship, amenable to determination by motion for summary judgment, that might be another route to early disposition. But again, that is usually the exception, not the rule," says Pilo.

Texas practice now requires a plaintiff to file a written report from a qualified expert within a specified period of time after filing of the lawsuit. "If the statutory requirements are not met, this would be another possible avenue to an early motion to dismiss," says Pilo. "However, this procedure is specific to Texas law."

Be Aggressive from the Outset

Justin Greenfelder, JD, an associate attorney in Canton, OH-based Buckingham, Doolittle & Burroughs, adds that the ED physician and attorney should be aggressive in defending the case from the outset, including commencing discovery.

"Let the plaintiff's attorney know that he or she is in for a fight," says Greenfelder. "If there are a number of defendants, and the ED physician is not the target defendant, the plaintiff's attorney may dismiss the aggressive ED physician and focus instead on the other, more passive defendants."

Aggressive actions will primarily be the responsibility of the physician's attorney and may include quickly serving discovery requests, filing appropriate motions if there are defects in the pleadings or evidentiary issues arise, pushing for the scheduling of the plaintiff's deposition and taking the lead aggressively in those depositions, and posturing the case early on to effect an early dismissal of the physician.

If named in a lawsuit, cooperate with your attorney in all facets of the litigation. "This will increase the likelihood that the attorney can pick apart the plaintiff's claim," says Greenfelder. This means making yourself available to meet with your attorney within a week or two after suit has been filed to discuss the case, being available by phone when your attorney needs to speak to you, providing your chart to the attorney for early evaluation, giving feedback promptly, and being diligent in preparation for your deposition.

Since the ED physician's deposition is of utmost importance, he or she "should know the medical record back and forth," and practice the types of questions that are likely to be asked, says Greenfelder. "The plaintiff's attorney not only wants to know what the physician did, but also is sizing up how good a witness the physician will be. If the physician does well, that increases the likelihood that the suit may be dismissed against him or her. If he or she does poorly, expect to be in for the long haul."

With regard to retaining experts, defense attorneys usually prefer experts who do not know the defendant physician, so there can be no insinuation to the jury that the expert is biased, says Greenfelder. As a defendant, the ED physician may make recommendations for potential experts, but should leave the final decision to the judgment of the attorney, says Greenfelder, "who should pick an expert who not only is strong on the medicine, but who also is experienced in understanding the importance of testifying effectively in a deposition and before a jury."

Experts May Not Be Qualified

Carrie W. McCutcheon, JD, an attorney at Baker, Donelson, Bearman, Caldwell & Berkowitz, PC, in Nashville, TN, says that once a lawsuit has been filed, the provider should very quickly retain one or two excellent experts who can help to "shape the defense and the story of the care the ED physician provided."

"The expert will help show the standard of the care for the ED physician and how his or her responsibilities are different from those of a nurse, a radiologist, or another provider," she says.

McCutcheon says that the lack of a competent and qualified expert can doom a patient's case. For example, under Tennessee statute, an expert must have been licensed to practice in the state or in a contiguous bordering state in a profession or specialty that

Sources

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would make the person's testimony relevant to the issues in the case. Also, the expert has to have practiced this profession or specialty in Tennessee or a bordering state during the year preceding the date that the alleged injury or wrongful act occurred.

Therefore, for example, if the only expert a plaintiff could produce was someone licensed and practicing in South Dakota, that expert would not be qualified to testify. Similarly, if the expert is licensed and practicing in Tennessee, but is a nurse and is offering opinion testimony against an ED physician, the expert would not be qualified to testify. Nor would an expert who was licensed and practicing in Tennessee or a contiguous state for only six months before the date of injury.

Should You Move for Sanctions?

If a lawsuit doesn't go forward because it's baseless, Feltes says to resist the urge to try to file a counterclaim for malicious prosecution or a related theory. "These are tough to prove and complicate the suit," he says.

While many states have statutes in place that permit a defendant to move for sanctions against a plaintiff and/or his attorney if the litigation proves to be frivolous, Feltes says "this is a difficult burden to meet. Courts are often reluctant to sanction plaintiffs or their attorneys in malpractice cases."

Another alternative is Civil Rule 11, a version of which all states have enacted, which permits a court to sanction an attorney for filing a document without a good faith basis.

"Again, such sanctions are rarely granted," says Feltes. "A third option would be a countersuit for abuse of process or malicious prosecution. However, these claims are rarely successful, given the high burden of proof and difficulty in penetrating the attorney's mental thought processes."

Pilo says that an ED physician's ability to recoup

expenses after prevailing in a medical negligence action would be determined under state law, and attorneys' fees are not generally not recoverable on a negligence cause of action. "If a case is tried to verdict and the defendant physician prevails, the defendant normally would be entitled to recover amounts which were properly taxable as court costs," says Pilo. "These would typically include filing fees and deposition transcript expenses, which would invariably be far less than the total cost of defense."

CNE/CME *Questions*

35. EMTALA's definition of "stabilizing treatment" requires that a patient be given pain medication upon request, regardless of whether pain control is necessary to stabilize the patient.
    A. True
    B. False

36. A study that polled nearly a thousand nurses revealed which of following behaviors most often led them to believe a patient was a drug-seeker?
    A. Going to different emergency departments for opioids
    B. Telling inconsistent stories of pain or medical history
    C. Asking for a refill due to lost or stolen medication
    D. All of the above

37. Which is likely to be a mitigating factor for an ED physician who is sued for a missed myocardial infarction (MI)?
    A. The ED physician's disposition is consistent with the documented cardiac risk stratification.
    B. The ED physician never discussed the challenges of MI diagnosis with the patient.
    C. No follow up calls were made to the patient.
    D. A just-obtained EKG was not compared to the patient's previous one.

38. Which of the following should the ED physician *avoid* doing to reduce risks of a lawsuit alleging a missed MI?
    A. Acknowledging to the patient's family that there is an inability to make the correct diagnosis of an MI 100% of the time
    B. Contacting the patient's primary care physician
    C. Conferring with the on-call cardiologist
    D. Instructing nurses to avoid making follow-up calls to a discharged patient later that day or the following morning

39. Which action is recommended in the event that an ED physician is sued for malpractice?
    A. Always choose an expert witness who knows you personally.
    B. Allow your attorney to make the final decision about the defense expert.
    C. Do not retain experts early in the process.
    D. File a counterclaim for malicious prosecution for any lawsuit that is filed.

Answers: 35. B, 36. D, 37. A, 38. D, 39. B

CNE/CME Objectives

After completing this activity, participants will be able to:

1. Identify legal issues relating to emergency medicine practice;
2. Explain how these issues affect nurses, physicians, legal counsel, management, and patients.
3. Integrate practical solutions to reduce risk into the ED practitioner's daily practices. ■

CNE/CME Instructions

Physicians and nurses participate in this CNE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity, you must complete the evaluation form provided and return it in the reply envelope to receive a letter of credit. When your evaluation is received, a letter of credit will be mailed to you. ■

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